Task Force For Selecting New Children's Instruments

Synopsis of August 7, 2001 Meeting

A meeting of the Task Force for Selecting New Children's Performance Outcome Instruments was held on Tuesday, August 7, 2001, at the Sacramento Airport Host Hotel. The topics of discussion and the actions that were recommended are highlighted below.

- **Welcoming Remarks and Introductions** – Jim Higgins, Department of Mental Health (DMH), led introductions and reviewed the agenda. Representatives from the following counties were present: Astrid Beigel (Los Angeles County); Tracy Herbert and Sue Farley (Sacramento County); Rudy Arrieta (San Joaquin County); Mark Morrison and Carol Adams (Stanislaus County); Gary Spicer and Janet Biblin (Alameda County); and Mike Parmley (Kern County). Abram Rosenblatt represented the UCSF Child Services Research Group. Luis Zanartu represented DMH Children's System of Care. Sherrie Sala-Moore and Brenda Golladay represented the DMH Research and Performance Outcomes Development (RPOD).

- **Pilot County Report** – Participating counties present at the Task Force meeting presented an update of their current implementation status:

  Sacramento: Sacramento county presented a handout to Task Force Members listing the comments and observations of those individuals involved in the pilot study. The comments were as follows:

  Ease of Administration – Time to Complete

  - Easier for parent and child to complete and, as a result, it is easier for the clinician to engage the client.
  - Answers range from less time consuming to complete to more work for clinicians than old form.
  - Better than old form, but needs to be cleaned up (not all risk factor questions are relevant – e.g., bio/foster parent)

  Ease of Administration – How Easy To Read and Understand?

  - Risk factor may need to be re-administered at mid-treatment because of all the unknowns at intake.
  - Trouble answering some questions make it harder to rate (CBCL ask for more specific answers).
  - Not relevant for certain groups (dating, using money wisely, job skills).
  - Profiles are easier to read. Profiles are available immediately.
  - Does not apply affects the overall rating.
  - Questions are too general.
  - Several incidences where two questions are being asked as one.

  Value of Data Collected – For Developing Treatment Plan

  - Like Ohio Scale better because outcome can be put in treatment plan immediately.
  - Clinician has more leeway to incorporate findings in their plans.
  - Parent was able to compare intake with mid-treatment and see progress.

Culturally Neutral/Nonbiased

- Need more culturally related questions on the form.
- Clients have some trouble with the interpretation of the questions.

Strength-Based

- The way the questions are worded it is hard to find the strengths.
- 3 negative and 2 strength based questions.
- Doing very well to okay choices leaves a gap.
- Questions should be more open-ended.
- Questions should allow a list of strengths to choose from.

Suitability for Target Population

- Some have just been placed in Foster Home and can't answer the questions.
- Behavior is overrated (does not note severity of single incidence).
- Better than CAFAS.
- Feel it captures the population of the client.

Long-Term Use of System

- Better, shorter, faster, less intimidating.
- Parents and kids like it better.
- May not show more positive outcomes over time because the kids are rating higher strengths at intake.

Alameda: The instruments have been administered at one site and the pilot study is drawing close to an end. There is some anxiety about any change in instrumentation. Performance Outcome compliance is spotty across providers, but most people are interested in what is happening.

Los Angeles: Clinicians do not like any aspect regarding the collection of outcome data. The primary reason the Ohio Scales are preferred are because they are easier to complete. Feedback can be gathered about the program and system level, but, at this point in the Pilot Study, managers are not involved in this process.

San Joaquin: It would be helpful if there were a timeline outlining the series of events that are to take place with respect to the decision making process. Also, it would be interesting to see the outcomes of the Time 1/Time 2 administrations. This might increase compliance rates for completion of the instruments. If a change is made, there needs to be a flexible transition, a phase-in approach. The infrastructure needs to be in place.

Stanislaus: Although there has not yet been any demonstration of what can be done with the data, clinicians like the Ohio Scales because they are easier to complete. What will make a difference is what can be done with the data (e.g., reports generated). County staff is anxious for the decision to be made.

Kern: There continues to be positive comments. Meetings are scheduled with staff in mid-August.

- **Announcement –** The Systems of Care Division of the State DMH has a new Deputy Director named Dave Dawson.

- **Follow-Up On Any Data Issues –** One of the primary goals of the Pilot Study was to have the data collected represent the statewide mental health system demographics (as reflected in the Client Services Information (CSI) database). After reviewing the Pilot Study data, it became apparent that, for the most part, this goal is being reached, except for the lack of representation of African Americans. Counties were asked to try to increase the number of African American children participating in the Pilot Study, if possible.

  A discussion was held regarding the multiracial categories that were the result of clinicians being able to mark up to two options for the ethnicity. DMH staff presented an analysis of the ethnicity data. Task Force members agreed that it did not make sense to have the biracial categories presented independently since the numbers are small. An additional table was presented that incorporated the biracial categories into the broader, more commonly represented categories. DMH staff will review the most current CSI data to make sure the statewide representation benchmark is accurate.

- **Missing Item and "Does Not Apply" Item Analysis –** DMH Staff presented an analysis on the number of missing items and on the "Does Not Apply" category. The results are as follows:

  - On the Agency Worker Functional Scale (Items 1-20), out of 2,239 responses, only 10 (0.4%) could not be scored. For the Problem Scale (Items 21-40), out of 2,239 responses, only 10 (0.4%) could not be scored.

  - On the Parent Functional Scale (Items 1-20), out of 2,110 responses, only 50 (2.37%) could not be scored. For the Problem Scale (Items 21-40), out of 2,110 responses, only 41 (1.9%) could not be scored.

  - On the Youth Functional Scale (Items 1-20), out of 1,093 responses, only 15 (1.4%) could not be scored. For the Problem Scale (Items 21-40), out of 1,093 responses, only 16 (1.5%) could not be scored. Task Force members requested to see this analysis broken down by age groupings.

  - Items in the Functional Scale that had the most "Does Not Apply" responses were #3 (Dating or developing relationships with boyfriends or girlfriends), #9 (Participating in hobbies), #10 (Participating in recreational activities), #13 (Learning skills that will be useful for future jobs, and #17 (Earning money and learning how to use money wisely).

  - Of those items identified as having the most "Does Not Apply" responses, all were found to have statistically significant age and ethnicity differences except #13, which was found to have only statistically significant age differences.

  - Problem Items that had the most "Missing" responses were #27 (Using drugs or alcohol) and #34 (Feeling worthless or useless). Each of these items were found to have statistically significant differences by ethnicity and by primary diagnosis.

- **Youth Services Survey for Families (YSS-F) –** Task Force Members reviewed the Youth Services Survey for Families (YSS-F) data. It appears that, as is common with most surveys measuring satisfaction, a majority of the respondents report that they are satisfied with services. The one negative item, "I felt we were discriminated against," has been dropped from the final version of the YSS-F. A majority of the surveys sent to DMH had 25-26 of the items completed.

- **Summary on "Time To Complete" Responses –** Data presented in the "Time to Complete the Pilot Study Instruments" report were collected from Sacramento, Stanislaus, Tri-City, Tulare, Glenn and Kern counties (N=190). The results are as follows:

  - The ID/Risk Factor form was primarily completed by clinical staff at a mental health clinic. The average time it took to complete this form was 10.4 minutes, ranging from 3 to 36 minutes. Approximately 95% finished within 20 minutes.

  - The CLESP was primarily completed by clinical staff (86.14%), though some case managers were identified (11.45%). 83.73% were completed at a mental health clinic while 16.27 were completed in the field. The average time it took to complete this form was 10.2 minutes, ranging from 1 to 65 minutes. Approximately 99% finished within 20 minutes.

  - The Ohio Agency Worker form was primarily completed by clinical staff (86.71%), though some case managers were identified (12.03%). 86.93% were completed at a mental health clinic, while 13.07% were completed in the field. The average time it took to complete this form was 11.9 minutes, ranging from 1 to 69 minutes. Approximately 93% finished within 20 minutes.

  - With respect to the Ohio Parent form, 71.03% were completed at a mental health clinic, while 28.97 were completed in the field. 59.6% required no assistance, 28.8% required some assistance, 9.6% required substantial assistance and 2.1% required complete assistance. The average time it took to complete this form was 14.7 minutes, ranging from 0 to 72 minutes. Approximately 86% finished within 20 minutes.

  - With respect to the Ohio Youth form, 78.7% were completed at a mental health clinic, while 21.3 were completed in the field. 58.2% required no assistance, 25.4% required some assistance, 7.5% required substantial assistance and 9% required complete assistance. The average time it took to complete this form was 9.5 minutes, ranging from 0 to 36 minutes. Approximately 93% finished within 20 minutes. When analyzing this data by diagnosis, many youth completed the form within ten minutes, however some youth diagnosed with disruptive behavioral disorder and adjustment disorder took longer than 20 minutes to finish.

- **Severely Impaired CAFAS vs. Ohio Responses** – The Pilot Study CAFAS data were presented to Task Force members. Less than 7% of the Pilot Study sample can be classified as being severely impaired according to the CAFAS standards. Similarly, the Ohio Problem Scale data show that 4% of the Pilot Study sample is considered to be severely impaired. When comparing the CAFAS Severity levels to Ohio Problem Severity levels, it is evident that each instrument is measuring different components of behavior. The CAFAS is measuring atypical children while the Ohio is measuring typical children. Although there is a significant amount of overlap in the severe/non-severe categories, each instrument is targeting different children.

- **Post-Pilot Survey –** After reviewing the Post-Pilot Survey that is to be distributed to and completed by county staff attending the Pilot Study Debriefing Meetings, Task Force members felt that one potential problem may be due to questions asking respondents to compare the current system to the proposed system. Due to staff turnover, there might only be a small number of people who have experience with both systems. DMH wondered whether or not it would be helpful to provide both sets of tools to the respondents to compare each package as they are completing the Post-Pilot Survey so that they could at least be exposed to the current system instruments and judge which package they feel is better. Task Force Members felt that this would compromise the integrity of the survey

because looking at the instruments is different from actually completing them. It was decided that the survey would be designed in such a way that the first part could be filled out by every Pilot Study county representative and a second part comparing the instruments could be completed by those having experience with both systems.

- **Time 1 vs. Time 2 Responses –** Currently, DMH collected 170 Time 1/Time 2 matched records. Preliminary results showed the following:
  - With respect to CAFAS scores, 46.2% got better, 35.4% stayed the same, and 18.5% got worse.
  - Change in CAFAS scores correlated with the parent having other children in foster care at 0.189 (p=0.046), child drug use at –0.247 (p=0.007), child law violations at –0.246 (p=0.007) and child gang member at –0.214 (p=0.021).
  - With respect to Ohio Agency Worker Problem scores, 64.3% got better, 10.7% stayed the same, and 25.0% got worse. These results may be a small indicator of potential sensitivity to change. The Reliable Change Index (RCI) should be used to further explore this result.
  - Change in Ohio Agency Worker Problem scores correlated with the child neglect at -0.216 (p=0.022).
  - With respect to Ohio Parent Problem scores, 50.5% got better, 7.5% stayed the same, and 42.0% got worse.
  - Change in Ohio Parent Problem scores correlated with the parent having a history of physical abuse at -0.307 (p=0.036), child history of physical abuse at –0.271 (p=0.033), and child exposure to domestic violence at –0.253 (p=0.045).
  - With respect to Ohio Youth Problem scores, 55.0% got better, 10.0% stayed the same, and 35.0% got worse.
  - Change in Ohio Youth Problem scores correlated with the parent having a history of physical abuse at -0.416 (p=0.048).
- **Topics To Be Discussed at the Next Children's Task Force Meeting**
  - ✓ Report on Pilot County progress
  - ✓ Follow up on any data issues
  - ✓ Review summary pilot data
- **Next Meeting - Sacramento Airport Host Hotel, American Room**

  November 6, 2001

  10:00 AM – 3:00 PM